MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES
March 3, 2004
10:00 a.m. – 4:00 p.m.
Jefferson Room, Capitol Plaza
Jefferson City, Missouri

Official

Commissioners in attendance: Gregg Laiben, James Buchanan, Thomas Cartmell, Deborah Jantsch, Susan Kendig, Nancy Kimmel, Scott Lakin, Kathryn Nelson, Bea Roam, Stephen Smith, James Utley, Kenneth Vuylsteke, and Tina Steinman.

I. CALL TO ORDER
Dr. Gregg Laiben, Chairperson
The meeting was called to order at 10:10 AM. Silent roll call was taken.

Review of Draft Minutes from the previous meeting:

Kathryn Nelson noted several corrections. MDI staff will make technical corrections. Scott Lakin moved to approve as amended. Dr. Buchanan seconded. The minutes were approved on a voice vote as amended with no objections.

Housekeeping items:

Linda Bohrer reviewed today's handouts. Three go with today's presenters. Dr. Drees has no visual presentation and no handouts. One handout is a notice from Lori Scheidt regarding passage of a patient safety bill in New Jersey.

MDI continues to post links to national patient safety websites. A link has been added to the National Academy of State Health Policy Publications. Many publications can be downloaded electronically for free. Other publications require payment from general public users, but MDI staff can request free copies. One such publication has been ordered. Kathryn Nelson has requested three more. If any Commissioner sees a cost publication they want, tell Linda Bohrer and MDI staff will request it.

There is only one more presenter scheduled, for a meeting in May. All remaining meetings are dedicated to discussion and work time for the Commissioners.

The next Commission meeting will be at the Capital Plaza Hotel.

The transcript of Dr. Hickson's presentation has been sent to all Commissioners.

II. PRESENTATION FROM UMKC MEDICAL SCHOOL ON CHANGES TO THE PHYSICIAN CURRICULUM

Dr. Betty Drees, Dean of the UMKC Medical School, described the current UMKC medical school curriculum, emphasizing the steps taken to include better practice and personal skills in standard class work:

- The latest Institute of Medicine (IOM) report on patient safety issues urged more attention to be paid in medical schools to practice competencies. The report emphasized that it takes more than paper tests or treating one patient at a time. Doctors must be trained to work as team members, and must be trained to pay attention to medical informatics that can reveal population-wide trends and potential problems. The IOM report also suggested that toughening the accreditation process, the licensure process, and the physician certification process should strengthen medical training.
- Dr. Drees felt that the continuing medical education of faculty should particularly focus on teaching teamwork, informatics and patient interaction skills. While stated curriculum can encompass these things, if faculty is not prepared to teach in this manner, the "hidden" curriculum will not match the stated curriculum.
- Medical schools are starting to make these shifts, but it will take a long time. It will also take leadership and commitment.
- Medical schools shouldn't just pile additional courses on informatics and personal interaction on top of existing classes. No medical school is going to stop teaching the basic core scientific curricula required to practice medicine. But classes like anatomy can be taught in a new way. For example, students can be observed doing physical examinations where they apply anatomical information.
- UMKC's medical program is one where freshmen right out of high school begin as medical students and go for six years. Hands-on clinical experience starts in the first year. UMKC has good clinical partners that share a focus on patient safety issues. UMKC adopted competency-based curriculum in the mid 1990's and recently moved to a new examination process. The curriculum focuses strongly on patient-centered practices and professionalism. Students are required to use electronic medical records. All students are matched for four years with a practicing doctor, called "Continuity Clinics". Students are taught to gather and use data on their own practice. In general, there are many opportunities to weave the IOM competencies into regular curriculum.
- Students learn more from reviewing their own outcomes data than from almost any other source.
- None of the changes the IOM report described are free.

Q: Could the new board requirements for physical examinations be extended to nurse practitioners and international students?
A: The new requirements are already applied to international students. The board process involves many steps. Several steps are undergoing changes. One change is to include observation of a physical exam. The boards are the paths to licensure. The

boards think that students are generally not leaving medical school with adequate examination skills.
Q: Will demonstration of examination skills be a requirement for graduation?
A: It depends on the school. Since the board requirement is brand new, it's too soon to see if the graduation requirements at UMKC will be changed. However, exam skills shouldn't be pushed off onto residency programs. By then, it's too late.
Q: You mentioned a course on professionalism. Please expand on what this is.
A: It's not "a" course on it's own. Professionalism is worked into ethics classes. It includes self-awareness, life-long learning and working on teams. Students are evaluated each month on professionalism. Students are provided examples of outstanding professionalism, and also unacceptable professional behavior. There is a demonstration project for looking at better ways to evaluate professionalism. Time is built in for reflection - going over a situation and thinking about critical events. Students work through their feelings through journaling.
Q: How does UMKC give students time to learn to use data?
A: This isn't yet implemented. Clearly, time to do it is critical. Use of data must be developed to fit into the existing schedule. It should be noted that reimbursement discourages anyone in practice from taking time to reflect and evaluate data.
Q: What do you recommend for this Patient Safety Commission? What should we tell the Governor about medical education in order to meet the quality improvement and patient safety goals we are charged to address?
A: Funding structures must be addressed. Academic and Medicaid support is too fragile. Legislative action for funding to support this type of curriculum is needed.
Q: Quality improvement and patient safety are separate but related issues. Does UMKC teach students to perform root cause analysis? Are students taught how to promote and function in a culture of patient safety? Is there something physicians should be taught in order to better grasp these issues?
A: Patient safety winds up being tied to the culture of partner hospitals at UMKC. The hospitals are moving to patient safety cultures. Another way could be through granting promotion based on safety. But the medical school is not leading patient safety in the hospitals.
Q: If there were funding tied to teaching root cause analysis, can that be done, or is the curriculum too full to add this?
A: It should be done. Systems analysis calls for application of evidence based decisions and teamwork. Medical schools are a safer environment for looking at near misses. No student should graduate without participating in at least one root cause analysis.

Dr. Jantsch suggested that habits learned in school and residency are very hard to break. The traditional response to errors is defensive medicine. **The legislature needs to invest in patient safety at the educational level.**

Susan Kendig pointed out that there are many similarities with nurse education, especially the issue of continuing medical education for faculty. This could be an avenue for collaboration between professional groups. Dr. Drees agreed and suggested that one silver lining to otherwise bad budget times has been better collaboration between professional groups.

Kathryn Nelson noted that nursing, medical and medical informatics students at UMC are all being taught root cause analysis, but there is frustration in knowing that many of them will go on to work in institutions that are not embracing these techniques.

III. PRESENTATION ON PATIENT SAFETY IN PRIMARY CARE

Dr. Robert Phillips

Provided information on the Robert Graham Center, focusing on family practice and primary care. The Robert Graham Center promotes examination of safety and malpractice issues in primary care, on the grounds that primary care is the first point of contact, and the main source of treatment, for most people in the medical system.

In addition to the information contained in his handout, Dr. Phillips made the following points:

- The Robert Graham Center is located in Washington DC for the purpose of providing information to national public health policy makers. However, the work of the Center is valuable to state initiatives addressing patient safety.
- Primary care providers are willing to participate in reporting. Errors occur in primary care much more often than most people think.
- Two studies conducted by the Center on patient safety in primary care are due to be published in April.
- The majority of treatment is delivered in primary care settings. That means the bulk of medical problems never present in a hospital. **Patient safety efforts aimed solely at hospitals will miss the biggest area for safety improvement.**
- 60 percent of people with heart disease, stroke, hypertension, diabetes, cancer, emphysema, chronic bronchitis, asthma, anxiety and depression go to primary care physicians for these conditions. They don't go to specialists.
- Family practitioners in rural and suburban areas of Missouri are often the difference between having an adequate supply of providers and having a health professional shortage area. These practitioners are away from major hospitals, and safety efforts focused at hospitals will disproportionately exclude people in rural and suburban areas.
- The Robert Graham Center worked with the Physician Insurers Association of America because they have medical malpractice settlement data that can be combined with data on litigated cases. Settlement data is good for categorizing errors into categories reflecting type or reason for error. However, it doesn't help suggest ways to fix problems. The Center continues to work with PIAA to answer the need for data on systems failures.
- The two studies conducted by the Center used 50 PCPs. The PCPs reported the errors they encountered in their practices. Error was defined to mean something that happened that the doctor felt should not have happened, and that the doctor doesn't want to see happen again. Follow-up studies extended the research to other professionals and to labs.

- A taxonomy of types of primary care errors was developed and published. Researchers in New Zealand frequently commented on how errors associated with administration, records and scheduling didn't occur in countries where computerized systems were wide-spread in primary care settings, the UK and New Zealand for example. Canada and the US still rely on paper records.
- The studies found that two thirds of all errors have their root in a communication failure.

DISCUSSION:
Q: The handout mentions a category for payment errors. What does that mean?
A: Payment errors might include situations where the patient is referred to a doctor that's no longer in the network, or the co-payment for an office visit has changed, but the patient and doctor don't know that at the time services are rendered.

- For common, serious problems, the US and Canada both exhibit problems with incomplete charts and labs. The US additionally exhibits problems with message handling and incorrect treatment decisions. England exhibits problems with patient flow and ignoring standard practice. New Zealand exhibits a problem with communication among different providers. So computerized records systems help reduce certain types of errors, but won't address all the errors that can commonly occur in a primary care setting.
- Health care system overuse is a significant problem in the US.

Q: How did you overcome fear of discovery?
A: Doctors participating in the study were allowed to report anonymously. However, they demanded feedback. Due to inability to promise legal immunity, researchers were not able to provide individualized feedback. The AHRQ is lobbying to be seen as a protected patient safety entity. However, researchers found that the act of reporting was often feedback enough. In focus groups, participating doctors commented that having to report repeatedly on the same or related issues would prompt them to try to implement system solutions that would prevent similar errors in the future.

- In study of lab error rates, recall that half a billion primary care visits occur per year. That means a huge number of people are touched by lab errors.
- Boards require certified physicians to engage in a quality improvement initiative each year. **State licensure boards recognize this. It would take legislation.**
- **Ask doctors what state policy makers could do to empower doctors to respond to best practice recommendations made by the professional associations.**

Q: Do you have data on the safety of APNs vs. doctors?
A: No
Susan Kendig indicated that the Missouri Nurses Association has data on this issue.
Q: How did other countries wind up with all computerized systems?
A: In England, the government paid for it. In New Zealand, which is a little more like the US, the government provided a subsidy that helped, but didn't totally cover costs. Peer pressure helped. It also helped that there were only four computer system vendors and their systems were very similar. In the US there are 180 or more vendors and systems are highly proprietary. **There needs to be data standardization.** If this can be done, uptake of computerized records will increase.

Q: PCPs have limited control over some safety issues, for example running down lab results. Is there support for staff development for PCP offices?
A: Not that I know of.
Q: What are your thoughts on why lab problems occur in the US and Canada, but not England?
A: Don't really know. Other countries have these errors, just not as often. It helps to have electronic systems because they remove some of the areas where errors can occur.
Q: Near misses and underlying causes are related issues, if not the same things. **How can we get voluntary reporting of near misses?** Is it the anonymity?
A: The problem with anonymity is feedback. However, you can't get carried away with protection. **You must address sub-par performers. Settlement data does contain near misses.**
Q: Do you have a method for tracking how often patients fail to follow through with getting labs or prescriptions as ordered by their doctors?
A: Not really. There's limited capability to get at this with computerized systems. Patients still have to take some responsibility for follow through. Often the default system is calling the patient instead of or in addition to calling the lab about a test result that hasn't yet been received. Reimbursement rates often don't factor in the time involved to track down lab results by Dr. or staff.

The Commission broke for lunch at noon and reconvened at 1:05 PM.

IV. PRESENTATION ON A PSHYCOLOGIST'S APPROACH TO PHYSICIAN REMEDIATION

Dr. Jim Dugan of Fortisan Group, LLC

Presented on their process for coaching providers in better interpersonal skills to reduce the risk of medical malpractice. In addition to information in his handouts, Dr. Dugan provided the following information:

- Colleagues at Fortisan are doctors, lawyers and business people.
- Past research into successful entrepreneurs found unique interpersonal skill sets that could be taught to others. The same has been found for some lawyers. The same appears to be true for doctors in terms of avoiding malpractice litigation.
- Fortisan offers a program that will teach doctors improved interpersonal skills aimed directly at reducing medical malpractice litigation.
- In addition to relational problems and accusations of patient abandonment, people filing medical malpractice lawsuits comment that the doctor discounted the feelings or statements of the patient or the patient's family.
- Fortisan looked at research where visits were transcribed and certain phrases, language styles and communication styles were coded. Certain codes correlated highly to risk of litigation.
- Researchers also found that high-risk doctors spent an average of 15 minutes with a patient, and low-risk doctors spent an average of 18 minutes with a patient.
- Research shows that manner and tone are as important as content in the statements doctors make to patients. Primary care providers tended to have better tones than surgeons. However, surgeons didn't know they exhibited any problematic

communication styles. Voice tone research outside the field of medicine also shows the predictive power of tone on outcomes.

- The Eagle Patient Simulator was developed for anesthesiologists to practice crisis situations or high-risk encounters. Fortisan wants to give similar practice situations to all doctors, to learn the right communication styles. Facilitators at Fortisan are surgeons and PCPs themselves. The goal is to practice until the right responses are automatic. To build new habits, it's necessary to activate the emotional regulator through practice. The technique comes from the field of affective neuroscience.

DISCUSSION:

Q: Are there any studies on the type of person that, as a patient, is more or less likely to respond by suing?

A: Don't know of any. Some medical schools teach students about "difficult" or "demanding" patients. The medical visit is a stressful situation for both doctors and patients. Patients are experiencing fear at varying levels. Sometimes the office system is the problem leading to litigation. Fortisan tries to address these system issues too.

- Fortisan uses the same coding system on reassessment for identifying the communication style the doctor is using after the intervention.
- A lawsuit usually involves more than a single incident. Usually a chain of incidents leads to litigation.

Q: How does a doctor get into your program?

A: They don't tend to self-refer. Sometimes their staff makes a referral. Fortisan tried to interest medical malpractice insurers, but they want proof that the intervention works. Fortisan is still working on gathering this data.

- Scott Lakin suggested contacting the new Joint Underwriting Association. The JUA may incorporate some innovative underwriting criteria. Dr. Jantsch suggested contacting medical managers and medical staff. They have a big need for the kinds of interventions Fortisan offers.

Q: What kind of reasons do you find for why doctors get sued? For example, do you ever find that plaintiffs desire to sue is driven by a lawyer?

A: By the time a doctor is up to 5, 6 or 7 cases, it's a variety of factors. Fortisan will actually bring in family members and spouses to get to the underlying personal factors. Fortisan will refer a doctor on for professional help or psychiatric intervention if that's warranted.

Q: Do you look at complaints against a doctor in addition to medical malpractices cases against that doctor?

A: Hadn't seen the research on this prior to reviewing Missouri's Patient Safety Commission web site, so no.

Q: How many types of high-risk encounters is Fortisan finding?

A: The main ones are breaking bad news to patients, unexpected outcomes and mishandling messages. Again, a chain of events builds to the point a patient files a suit. Every doctor encounters these situations. Rather than trying to avoid high-risk encounters, Fortisan gives doctors a forum to practice dealing with these situations.

Q: Do you think you'll extend this type of training to other professions?

A: The IOM report has recommendations on this. Two of the recommendations are leadership and enhanced communication. The attributes Fortisan identifies are applicable to the whole team of health care providers.
Q: What's the typical length of the remediation program?
A: Fortisan offers 3-month, 6-month, 9-month and 12-month programs. An unannounced standardized patient is sent to assess and reassess the provider.
Q: How much does Fortisan's process cost, and who's paying it?
A: The initial work-up (review of medical malpractice history) is $1500. Most are paying out of their own pockets. With multiple med mal cases, the cost of the remediation program is not the biggest financial issue.
Q: Is there initial resistance, and how do you overcome it?
A: Responses are mixed. The research we provide helps get buy-in to the problem. Fortisan is careful to fully explain the process and to emphasize that it's not a huge time commitment for the doctor.
Q: Do doctors come to your program before, during or after they experience litigation?
A: There are no "before" doctors. Fortisan has done some demonstration seminars. Responses have been interesting. Doctors with many years of practice experience are excited and validate the situations that Fortisan identifies. Residents with little practice experience are much more skeptical. This could be just information overload that most residents are experiencing.
Q: What do you think of the theories that women are less likely to be sued than men?
A: There are not enough female surgeons. Insufficient sample size to draw any conclusions.
Dr. Laiben briefly described a program at St. John's where a bonus payment is tied to attending a seminar on how to diffuse high-risk encounters. St. John's is measuring the effectiveness of the program through patient satisfaction scores, but they are still waiting to see if there is a reduction in litigation risk. There are always skeptical doctors that attend only because they have to and they always seem to be convinced of the benefit by the end of the session.

The Commission took a break at 2:15.

V. PRESENTATION FROM DEPT. OF HEALTH AND SENIOR SERVICES ON THE UTAH/MISSOURI PROJECT

Susan Elder and Dr. Garland Land presented preliminary information on the study they are conducting in partnership with Utah to evaluate whether or not certain billing codes were good indicators of medical errors. In addition to the information in the handout, Ms. Elder presented the following:

- The codes being studied are in the medical record and discharge data.
- Chart reviews sampled records from hospitals in both states. Charts were reviewed before and after the project intervention.
- UMC Medical School is doing the project's hospital surveys. The first round of surveys was conducted in 2002. The second round has just been concluded.

- Intervention strategies were different in each state. Adverse event reports were based on the discharge data every hospital reports. In Missouri, the intervention conferences were handled by the QIO, Missouri PRO.
- Missouri focuses on surgeries because, in part, problems with surgery are less likely than drug problems to be related to issues the patient had before admission.
- DHSS provided a break-out of metro and non-metro hospitals for the feedback provided to hospitals. Feedback data was not risk-adjusted but certain areas of the report allow a hospital to see risk areas that might explain some variation.
- In commenting that medical record documentation was often insufficient to explain why a problem occurred, survey staff noted that medical records were usually limited to just factual statements that a problem had occurred.
- Administrative data will only capture events for which there is a code. Near miss information won't appear in any patient's records.
- Injury codes in the discharge data aren't captured with a date, so there is always a question on whether the injury occurred inside or outside the hospital. California is the only state that requires a date with the injury code.
- Researchers compared each state's experience and found that each state picked up events the other state had missed.
- In Missouri, some quality managers want extra copies of the reports and use the reports in their own safety initiatives.

DISCUSSION:

Q: **What's next on the research? What questions will be addressed in the future?**

A: In addition to refining discharge data, an updated survey needs to be done to assess the patient safety activities that hospitals are already doing. It's important to find out how wide spread best practices have become.

Kathryn Nelson commented that UMC is using the DHSS reports but would like to see if data can be gathered more timely. Also wanting to look closer at patients with multiple admissions and taking advantage of longitudinal data. UMC may not be the only hospital a patient goes to, and DHSS may have more complete longitudinal data records.

Q: Are e-codes in the patient's medical record, where the patient can get them?

A: Yes, however one problem is that the medical record will say there is an injury, but will not say what the injury was or when it occurred. Missouri is better than some other states in enforcing the use of discharge codes, but payment to the hospital doesn't change if the code is missing.

Q: Is the e-code an admission the hospital did something wrong?

A: Could be. (Lois Kollmeyer mentioned sub-codes, but Ms. Elder noted that billers don't pay attention to sub-codes.)

Q: Isn't a hospital discouraged from reporting this if a lawyer can get to it?

A: (Dr. Land) There are actually two separate codes. One shows an injury and the other shows how the injury occurred. So part of what DHSS is studying is how discharge data varies from what's in the medical records.

Q: What keeps the hospital from lying about the codes for iatrogenic events?

A: Discharge data reported to DHSS is protected. DHSS's public reports aren't protected, obviously, but if data isn't used to publish a report, the data isn't public. The

study is to try and determine how good the data is. If the data is found to be good, DHSS may decide to publish.

Q: But can't a lawyer request the same billing data being reported to DHSS? Can't I tell if the injury occurred in the hospital?

A: Not necessarily. For example, an ICD code may be entered for a drug overdose. It doesn't say if the overdose occurred in the hospital, or was the reason for hospitalization. That's where a date would help. That's why liability isn't a concern.

- **Garland Land continued by discussing the possibility of using the data to look at process measures instead of outcomes measures. DHSS's experience with publishing reports on processes found that hospitals would adopt the desired process following a public report if the hospital had a local competitor.** Hospitals in markets without a competitor were less likely to adopt the desirable process. So **public information can drive change.** It's important because the diffusion of new science in medicine is very slow. There's a need to adopt safety practices sooner than they will be adopted if no public reporting occurs.
- It's easier to measure processes than to measure outcomes.

Q: DHSS says look at multiple data sources. How much can you distill from discharge data? When do you turn to an alternative source?

A: There are still more analysis opportunities in discharge data, based on AHRQ measures. Analysis of discharge data is just getting started, really. But that doesn't mean you can't look *now* at supplemental sources. There's no gold standard, meaning no single source of information will be perfect.

Q: It's generally accepted that data dissemination and adoption takes 17 years. Two million people will die due to patient safety issues in this time. What can we do now, or do soon, so that these people don't have to die?

A: **Focus on process measures that have broad impact regardless of the specific problems**. With regard to AHRQ's book on best practices for patient safety **find out which hospitals are using this book, and what are they doing. Address protection issues.** Don't worry about the ideal data set because it's not possible, or not possible at an affordable price. **Administrative data like discharge data isn't going away. Take advantage of what it can offer. Require sentinel event reporting, and make it available to the state agencies.** Right now, it's voluntary in Missouri and reports go to JCAHO, not any state agency. **Use data to give hospitals feedback.** Don't use it to beat them up.

As a final point, Ms. Elder noted that their report is due to be published August 30, 2004.

VI. PRESENTATION BY DWIGHT FINE CANCELLED

Mr. Fine was not able to present.

VII. GENERAL COMMISSION DISCUSSION

Linda Bohrer and Kathryn Nelson presented their preliminary report on an overview of Patient Safety Centers for the Commission to consider different models. A draft was passed out, noting primary decisions that would have to be made about establishing a permanent patient safety center in Missouri.

The Commissioners discussed at length how detailed their report to the Governor needs to be, and how detailed the recommendation to establish a Patient Safety Center needs to be. It was decided that the draft that Kathryn Nelson, MDI staff and staff from MissouriPRO and the hospital association had presented was as detailed as it needed to be for purposes of making a recommendation to the Governor.

Scott Lakin and Randy McConnell spoke of the need to tie the recommendations to the testimony heard.

The remaining areas that the Commission wants subcommittees to research and report back on were:

- Protection and disclosure
- Data/reporting
- Education and patient empowerment

Leaders were assigned to each area. Other Commissioners need to volunteer for a group. MDI staff will get a posting out so that Commissioners absent today can pick a group. The next meeting will start with subgroups meeting on their own to finalize their findings. The afternoon will be devoted to presentation by each group and discussion. Group leaders should contact Linda Bohrer about any staffing and materials needs. Groups are encouraged to meet as needed before the next Commission meeting to prepare.

There were no public comments. The meeting adjourned at 4:10 PM.